

THE RHODE ISLAND MEDICAL JOURNAL

The Official Organ of the Rhode Island Medical Society
Issued Monthly under the direction of the Publication Committee

VOLUME XIX { Whole No. 317
NUMBER 2

PROVIDENCE, R. I., FEBRUARY, 1936

PER YEAR \$2.00
SINGLE COPY 25 CENTS

ORIGINAL ARTICLES

ANNUAL ADDRESS BY THE PRESIDENT OF THE PROVIDENCE MEDICAL ASSOCIATION,

WILLIAM P. BUFFUM,
122 WATERMAN ST., PROVIDENCE, R. I.

My last duty in office is to address you on the work and needs of the Association, but before this I want to say a word about the past year. The work has been a pleasure, every minute of it. The meetings have been of scientific character, which except under unusual circumstances I believe they should be, and the different committees without exception have done their duties well under the direction of able chairmen. The Committee on Relief Care under the F.E.R.A. by very strenuous and skilful efforts have been able to make this plan work reasonably well, and fortunately for them this work is finished. I feel that we owe a considerable debt of gratitude to Dr. DeWolf for his willingness to accept the chairmanship of the Committee on Medical Care of the Low Income Group. This study is very complicated and arduous and takes more time and effort than any physician usually expects to give to committee work.

Before I tackle my main subject, which is an economic one, I want to make an apology. This problem is entirely out of my line, and a presentation that is unworthy of a scientific body, is excusable only because of its importance at this time.

The subject is the Medical Care of the Low Income Group. In this group are included those families whose incomes cover the bare necessities of life, but which in the case of serious or protracted illness have no considerable funds to pay for medical care. Below this group are the indigent, who have not sufficient income for living and whose medical care is necessarily on a charitable basis. Above the low income group are the families whose incomes are more than enough to cover their basic needs,

and which theoretically at least should be able to obtain the services of a physician under all ordinary circumstances. Roughly speaking the low income group may include families with incomes between \$1,000 and \$1,500 a year. Of course it is evident that there are many complicating factors and that the need of each family must be judged on its own merits. I am mentioning these figures only to give a general indication of the type of families under discussion.

As to the amount of illness in these families I have few figures. In summarizing the results of very large and careful surveys conducted for the committee on the cost of medical care, Alden B. Mills¹ states that about seven days disabling sickness per person, per year, is the average. In considering these tables it must be remembered that the average person does not exist, that a few have much illness and that many have very little.

I have one interesting source of information on the relative amount of disease among the well to do and the poor, and that is Dr. Chapin's article² on death rates among the taxpayers and non-taxpayers. In getting these figures he had to go back to 1865, when there was an income tax, and the census list and the income tax list were both available. We need not go into this except to notice that he found the death rate among the non-taxpayers was more than double that among the taxpayers. This would indicate that, at that time at least, there was a very great deal more sickness among those with smaller incomes.

In the studies of the committee on the cost of medical care³ it was reported that in the nation-wide study of 9,000 white families there was substantially the same amount of sickness among the various broad income groups. Data from the U. S. Public Health Service⁴ show that in the group with income less than \$2,000 there is a definite relationship between poverty and amount of illness, the poor families having the more illness. At any rate these findings do not indicate that there is markedly less illness among the poor than among the well to do.

In the United States as a whole, the lower the income, the less medical care is given. The following table was based on the study of 38,668 persons.³

TABLE 1.

HOME, OFFICE AND CLINIC CALLS BY PHYSICIANS
PER 1,000 INDIVIDUALS IN ONE YEAR

Family Income	No. of Calls
Under \$1200	1931.9
\$1200-\$2000	2045.9
\$2000-\$3000	2296.7
\$3000-\$5000	2741.4
\$5000-\$10,000	3621.4
\$10,000 and over	4734.4
Services desirable (CCMC)	5649.5

From survey of 38,668 white persons, C.C.M.C.

This table shows clearly that in the United States as a whole, the low income group is obtaining a small amount of physicians' services. How true this is in Providence we can only surmise as yet.

The distribution of sickness cost is very uneven. Even the low income group family might obtain enough medical services from his family physician to get by, if the expenses were average, but on the contrary the amount of illness varies so much that the average gives small comfort. The following table shows the uneven distribution of cost.³

TABLE 2.

ANNUAL CHARGES FOR MEDICAL CARE PER FAMILY
WITH INCOME UNDER \$1200.

Under \$60	79.5%
\$60-\$100	9.9%
\$100-\$250	7.1%
\$250-\$500	2.5%
\$500 and over	1. %

3.5% of the families had charges of 30.9% of the total bill.

8,581 white families, C.C.M.C.

The next subject is income, how are incomes distributed. Table No. 3 is taken from "The Ability to Pay for Medical Care," by Louis S. Reed, Reprint No. 1684 from the Public Health Reports of the U. S. Public Health Service, and an estimate of my own.

TABLE 3.
DISTRIBUTION OF INCOMES

Incomes of Families	C.C.M.C. 1928	U.S.P.H. Survey of Relatively Poor Sections 1928	U.S.P.H. Survey of Same Families 1932	Estimate for Providence 1932
Under \$1,200	21.3%	26.4%	66 %	47.2%
Under \$2,000	55.3%	64.9%	89.5%	61.4%
Under \$3,000	76.8%	89.1%	97.5%	78.6%

The estimate for Providence in 1932 was obtained by correlating the first three columns and adding 20% to the incomes. This result is a guess rather than an estimate. If this guess is reasonably correct, the median income of families in Providence is not far from \$1,200.

What is the lowest level at which families can be expected to pay anything for medical care? A great many figures have been published giving ideas of different groups as to the cost of a minimum subsistence standard of living.

TABLE 4.

ESTIMATES OF THE COST OF A "MINIMUM SUBSISTENCE"
STANDARD OF LIVING⁵

Locality	Size of Family	Cost at 1929 Prices
Cleveland 1928	5	\$1,248.00
Chicago 1929	Mother and 4 children	1,054.00
Portland 1931	5	1,385.04
San Francisco 1931	5	1,383.20
New York 1931	5	1,353.47

By social agencies.

These average \$1,285 at 1929 prices.

If these figures are correct, nearly half the families of Providence are at or below the minimum subsistence level as calculated by these organizations.

I think it would be a mistake for me to try to make any clear cut deductions from this very superficial and hasty review of the medical-social situation. I am presenting it to you chiefly for consideration, so that we can form more correct ideas in the future. It does seem however that we can deduce that a very considerable proportion of the families are self-supporting but have no considerable funds to pay for sudden and serious illness.

The question will soon come up as to whether we should take some collective action to enable these families to get proper medical care and to pay for it in a self-respecting way, instead of either going without care or seeking charitable aid in the clinics and hospitals. Also some such plan might be used to correct the improper use of hospitals and clinics by those patients who are able to use regular private practice. Our committee will ultimately report as to whether some such action seems advisable to them, and at that time the Association must debate the question and make a decision. At

present it is well to start thinking about it, and I want to spend the rest of my time in presenting to you a possible plan.

This plan would involve establishing a bureau, probably in this Library. Patients could be referred to this bureau by their physician, and here could be determined their ability to pay. Bills could be sent to this bureau and, if they exceeded the amount that the patient could pay, our own secretary would have the power to reduce the total amount. Then he could collect this amount in weekly instalments, spread over one year.

The bureau might be constituted somewhat as follows: A committee of this association would act as board of directors. The chief executive would be a secretary, employed on a full time basis, if possible a physician, but at any rate a first class man with some experience in public health and social work.

The doctor could refer the patient to the bureau. The bureau could find out about the patient and his family by talking to him and possibly checking his income through his employer and through any organization which knew anything about him. Just how much house visiting would have to be done by this bureau is not yet determined, but probably very little.

The patient would go to his own doctor. The only part that the bureau would play would be: 1. At the request of the doctor, the bureau would determine the patient's ability to pay; and 2. The bureau would collect this amount during the ensuing year.

The usefulness of such a plan if it could be organized successfully might also be summed up in two sentences. 1. It would enable the patient of small income to get complete care. 2. It would enable the physician to obtain the compensation for his services up to the limits of the patient's ability to pay.

This set-up could probably co-operate with the hospitals and help prevent the small percentage, although considerable amount, of clinic abuse which is taking place at present.

Of course this is the barest outline of the general principles of such a plan. It would need very careful studying. If adopted it would need to be administered very well or otherwise would create abominable confusion.

In the main it should be started on as simple and small a basis as possible. We should not try to correct and change everything, but merely to make an effort to systematize for a small group of patients the old practice of fitting the bill to the ability of the patient to pay.

The last section of this address consists in quotations from the pamphlet of the Bureau of Economics of the A.M.A., "Medical Service Plans," a special report as approved by the House of Delegates, American Medical Association, 1935. The quotations are sentences and paragraphs that seem to be pertinent to the subject, and I have tried to be fair and not use statements which when isolated give a different impression than when in their proper context.

"The size of the problem which a medical society intends to attack should be definitely determined. Critics of medical society plans, especially when they are also advocates of some wholesale panacea like compulsory sickness insurance, are inclined to deprecate plans which cover only a comparatively small portion of the community. It is much easier to experiment with a small plan and expand it to a comprehensive one than to start with a big scheme involving new and cumbersome administrative machinery."

"The scope of the plan should be definitely determined in the beginning. A primary division will be between the indigent and the low income classes. By low income is meant an annual income so low that payment made for medical service will reduce the amounts available for such necessities as food, housing and clothing below good health standards, which are usually placed somewhere between \$900 and \$1,500, varying according to local conditions."

"Proper adjustment of medical charges according to ability to pay depends on as exact knowledge as is possible of the income of those to be served."

"A classification of illness with reference to the economic burden is another necessary preliminary step. Illnesses may be divided into 'minor' and 'major' or 'catastrophic.' Except for the indigent, the provision for medical service in minor illnesses is seldom an important economic problem. Wholesale provision for medical service for such illnesses usually results in an increase in their number. On the other hand, when expenditures in a family whose income is already close to the 'comfort' or even the 'subsistence' level reaches \$50 or more,

such a family may be forced into an economic situation destructive of the health of the entire family."

"Analyses show that the class for which special provision is necessary is far smaller than most lay writers and the results of so-called 'surveys' indicate. Elimination of the care of minor illness leaves only from 10 to 15 per cent of the low income class whose medical expenses each year constitute a heavy burden or so-called catastrophe."

"The problem of many of the remainder can be solved as well as the general economic situation permits by an approximate adjustment of fees, in accordance with a full and fair investigation of resources and accompanied by arrangements for instalment payments."

"When any income exists the care for minor illnesses usually requires little more than a possible adjustment of charges."

"The experience of the Wayne County, Mich. (Detroit) Medical Society has shown that the average charge to the persons receiving complete medical service, including hospitalization for major illnesses, is less per family than the majority of proposals for sickness insurance would impose on all families sick or well."

"It is possible still further to lighten the burden by the method through which the same classes are accustomed to purchase articles not ordinarily incurred in their family budgets, that is, by the instalment plan."

"Because collection does play so important a part in the economic side of the payment for medical service, many county medical societies have found it practicable to entrust the function of collection to a central office controlled by the county medical society. If this is done it is possible to co-ordinate and simplify all steps of the process."

"It will sometimes be impossible in the beginning of any plan to provide for the payment of the equivalent of ordinary full fees to all the physicians engaged, even if allowance is made for a sliding scale. The amount of gratuitous service which is to be given should be clearly understood, and it should be recognized that a certain amount of such service is involved in any form of medical service. At the same time it is a fact that a high grade of medical service cannot be provided permanently unless the payment for such service is sufficient to enable physicians to maintain that standard

by further education and a corresponding standard of living."

"No very elaborate or expensive administrative machinery is necessary, at least in the beginning of such program as is here suggested. A central administrative office will be required to which all calls for medical service should come or be reported. This office should then refer these to the investigating agency for an economic diagnosis and to some physician for a medical diagnosis and treatment or reference, if needed, to the proper institution. The introduction of such simple methods by county medical societies has, in some localities, either met many of the difficulties that previously existed in furnishing medical service to those needing it and who were hitherto unable to obtain it, or has opened the road to other equally short and simple steps toward progress in handling other difficulties."

"After such individual economic and medical diagnoses have been made it is possible to fix a fee and determine methods of payment which will meet the situation as well as the conflicting elements of income and need will permit. That is all and indeed far more than can be said for most wholesale schemes of reorganization of medical service."

This is the end of the quotations.

As you know, the spokesmen of the A.M.A. are insistent that no plan should be adopted hurriedly and that the local medical association should, before any such action, be sure that there is need for such a plan.

In conclusion I repeat that my object in discussing the situation and a possible plan is not to urge any action but to emphasize the importance of informing ourselves on this subject in order to be able to take intelligent action later when the committee report is made.

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1. Publication Number 2. Committee on the Cost of Medical Care. Alden B. Mills.
2. Chapin, C. V. Am. Jour. Pub. Health. 14:647; Aug. 1924.
3. Final Report of the Committee on the Cost of Medical Care.
4. Taken from Final Report of the Committee on the Cost of Medical Care, p. 7.
5. Publication No. 25. Committee on the Cost of Medical Care. Louis S. Reed.

THE RHODE ISLAND MEDICAL JOURNAL

Owned and Published by the Rhode Island Medical Society
Issued Monthly under the direction of the Publication Committee, 106 Francis Street

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SUBSCRIPTION PRICE, \$2.00 PER ANNUM, SINGLE COPIES, 25 CENTS.
Entered at Providence, R. I., Post Office as Second-class Matter.

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EDITORIALS

PRIVATE PRACTICE VS. SOCIALIZATION

Even the most enthusiastic protagonist of socialistic reform will be loath to advocate the establishment of State medicine as the initial step in a reorganization of society if he has clearly in mind certain facts pertaining to the present day practice of medicine in America. In the first place the profit motive, the elimination of which from economic life is a main objective of socialism, is both

by tradition and usage definitely subordinated in the life of the rank and file of the profession as it is in no other group of independent individuals. In the second place the institution of the private practice of medicine as at present carried on, in spite of many defects which must and will be remedied and which are being freely emphasized by a host of critics, is rendering at the present time an increasingly efficient service. In the third place successful socialization of the profession with the preservation of the essential relationship between doctor and patient, represents an ideal which at present appears impossible of achievement. Critics who, like Harold Laski in his recent article "The

Decline of the Professions" (Harpers, November) maintain that the struggle for existence on the part of the practitioner destroys his ability to render efficient, up to date service, forget that under a system of State medicine in which financial "security" would be guaranteed to the doctor there would be taken away from him that stimulus to excel, to "make good" in the eyes of his patients, which causes him to do his level best. Such critics do not sense the disruptive effects of bureaucratic control with all its opportunities for political machinations and injustice. Even in that preliminary move towards socialization which it must be admitted is a form of State medicine, the British Panel System, there is already as Johnson has pointed out (A.M.A. Bulletin October 1935) a definite restriction in the choice of physicians by the patients and a definite belief on the part of such patients that "panel treatment is not as good as private." As far as the status of the panel doctor is concerned Johnson quotes the Lord Chief Justice as follows: "The treatment of the panel doctors under the National Insurance Acts is *pure despotism.*" What such a system could do in Rhode Island, we who have first hand knowledge of our local conditions can hardly contemplate without a shudder.

Let us admit, then, for sake of argument that a measure of socialization of our general economic life would be a step in advance. Let us further admit that many improvements in the practice of medicine as at present organized are needed. Never-the-less, in view of the high character and achievements of the modern independent practitioner and of his traditional subordination of the profit motive in his work, and with a knowledge of the obvious dangers in all attempts at bureaucratic control, let us determine to resist any attempts to begin socialistic reform in the field where the need for it is obviously the least, the field of medical practice.

MERCY KILLING

Recent newspaper propaganda tending to inflame certain hysterical groups among the public in favor of legalizing Medical execution of patients deemed to be suffering from an incurable condition, is considerably out of line with the Principles of Medical Ethics as well as Individual Rights to "Life Liberty and the pursuit of Happiness."

It is true that we as Physicians as well as Individuals have come into close Medical and personal contacts with patients who not only are suffering acutely to no purpose and for whose life little hope remains. But it does not logically follow that we have a God-given right to deprive that patient of his life deliberately,—a process which the courts might very properly consider predetermined, planned, first degree murder.

It is also true that when Death finally comes to many aged and incurably afflicted patients, it comes in the garb of an Angel of relief, rather than a "Grim Reaper"—a final Benediction of Peace to one who has lived and worked long and hard, which is certainly a much desired reward, although permanent.

Fortunately we have the methods and drugs for giving peace, or relieving suffering and allaying pain, both physical and mental, which would seem fully adequate in every case, without adding the permanence of Death, which nature so generously provides at the proper time. Any change of criteria in that respect is fraught with the great danger of error, abuse, and in rare cases even of deliberate crime.

The Physician or individual who sponsors any such program of so-called "Mercy Killing" has a weak, warped sense of sympathy and is a most unsuitable person to make the decision which sentences a patient to death. Similarly, the patient, worn by protracted illness or suffering who begs for death, is temporarily, at least incapable of making so portentous a decision and should be ignored in that idea.

It is a matter of gratification that no Rhode Island doctor has demonstrated such a modernistic conception of moral ethics, or is likely to do so.

Let us take heed and "Hold fast to that which is good."

BRIGHT'S DISEASE

What a temptation—to rationalize a diagnosis of Bright's disease when treating a patient whose urine shows albumin and casts, but whose condition seems obscure. If we remember that in almost all severe illnesses the urine shows albumin and casts, we are cautious and do not speak too fast.

Coronary thrombosis, for instance, may be accompanied by cardiac decompensation, and if it is, the urine shows casts. If the patient is put on a strict diet he worries unnecessarily.

February, 1936

THE JOURNAL'S COLUMN

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THE JOURNAL'S COLUMN

To insure prompt attention, the readers of this JOURNAL are advised: That matters pertaining to advertising, mailing and accounts should be addressed the Business Manager, Dr. C. W. Skelton, 106 Francis Street, Providence, R. I.

Other matters, books for review, notices, manuscript, letters, reports of meetings, and all affairs of literary nature should be addressed to the Editor, Dr. Frederick N. Brown, 309 Olney Street, Providence, R. I.

AS TO BOOK REVIEWS

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Inasmuch as it is a compliment to be asked to review a scientific book, it is to be hoped in courtesy to the publishers that the review may be finished within a period of thirty days, the book sent to the Society's library and review to the Editor.

Should sixty days elapse before receipt of book (and review) the matter must be referred to the discretionary action of the Society in the recovery of its property.

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If Bright's disease is included in the family history, if statistics are clouded once more, it is because the urinalysis tripped us up.

"Bright's disease" may have been coronary thrombosis, carcinoma of the pancreas, cancer of the lung, syphilis or one of many other specific diseases. We may sign a death certificate nephritis or carcinoma. We may not be convinced, but guess it is one of several diseases we have thought of. We may be concerned about the relatives of the departed, they will feel better if we commit ourselves than if we admit we have not been able to determine the cause of death. We may say to ourselves, "medicine is not an exact science, even if it were, there would be a co-efficient of errors." If Bright's disease is worked into a family history where it does not belong, it is regrettable. We

depend upon our statistics and family histories to such an extent that an erroneous diagnosis on a death certificate is to be taken as seriously as if the patient were alive and his chances of recovery involved.

If we must admit we have come up with our limitations and do not know what killed the patient, we are not cheating science. We are, if we yield to the temptation of rationalizing, too broad a guess to comfort despondent relatives. The mention of a specific disease is a relief; it means, to most laymen, that the patient was doomed. Let us be human, but not sentimental—think of statistics and family history rather than expediency and good will. If we are baffled by an obscure case, a consultation will often help. If we are called at the bedside of a dying man and have no chance to ascertain the indirect cause of collapse, we may make a diagnosis, but is it correct?

**A CASE OF UREMIA (WITH PRESENTATION OF SPECIMENS—
POLYCYSTIC KIDNEYS)***

By KATHLEEN M. BARR, M.D.
105 WATERMAN STREET, PROVIDENCE, R. I.

When P. Z. W., a thirty-seven year old, white, American, male, contractor was admitted to the Memorial Hospital on March the seventh, nineteen thirty-five, with a diagnosis of Uremia, clinical signs and symptoms substantiated this, but it was not until he reached the autopsy room that the true cause of the uremia was revealed.

On admission he complained of blurring of vision, shortness of breath, dizziness, and edema of the ankles and scrotum. The dizziness and blurring of vision caused him to seek an eye examination. The ophthalmologist referred him for medical treatment. This was three weeks previous to admission. Ten days later, the edema appeared, and when this became much worse, the day previous, hospitalization was advised.

In his past history he recalled mumps, measles, chicken pox and whooping cough in childhood. Influenza and pneumonia in 1919. There was no history of venereal disease. When he had been in the hospital a week, he recalled having been treated for "kidney trouble" throughout the summer and fall of 1934.

*Read at the meeting of the Rhode Island Medical Society, September 1935.

In the family history there was found nothing relevant. His habits were very good. No alcohol used and only one-half package of cigarettes smoked daily.

At no time previous to the onset of his present illness did he complain of shortness of breath or any urinary symptoms. His appetite was good. He was beginning to notice some nervousness and felt that he was suffering from a heart condition.

Physical examination revealed a very well developed and well nourished white male, lying apparently comfortably in bed, seemingly mildly lethargic, and complaining of dizziness. There was puffiness of his eyelids. Pupils were equal but reacted sluggishly. His nose presented no pathology. His teeth were poor. Tongue heavily coated and pharynx injected. He was well developed as to chest. Resonance and breath sounds were diminished but no râles were heard. The heart was enlarged in all diameters; sounds were only fair in quality but the rate was regular, about 88. A 2 was accentuated. Blood pressure 196/130. The abdomen was pendulous, distended and edematous. The liver was felt three fingersbreadth below the costal margin. No tenderness could be elicited, nor could any masses be felt. The genitalia were edematous. Knee jerks were inactive.

The laboratory findings were as follows:

Urinalyses: The color was at all times pale yellow, varying in reaction, with a specific gravity ranging from 1.008 to 1.020. At all times a trace of albumin was noted. There were never any casts. Occasionally there were found red blood cells, bacteria, leucocytes and epithelial cells.

Blood Chemistries:

	Adm.	3/12	3/15
Urea Nitrogen	44.82	77.05	83.13
Creatinine	6.5	6.8	8.8
Sugar	123.	129.	134.

Complete Blood: Hgbn. 86%, R.B.C. 5,010,000, W.B.C. 7200, 65% Polys., 31% Lymphos., 2 Large Monos., 2 Transitionals.

Sedimentation Time: Presented a fast normal curve.

Wasserman and Hinton: Negative.

Kidney Function: Zero.

Electrocardiograph Readings (2): "Myocardial damage and left ventricular preponderance with probable involvement of coronaries."

- 1. Hypertension.
- 2. Uremia.
- 3. Nephritis.

The patient's progress: His temperature remained normal at all times with a pulse ranging from 80-90 and respirations 20. His blood pressure ranged from 196/130 to 150/96, but remained at about 180 systolic most of the time. His weight dropped from 179 lbs. to 153 lbs. in 12 days. His output of urine, measured daily, exceeded his intake of fluid at all times except on one occasion when the intake was 61 oz. and the output 51 oz.

The Treatment of the Case: On admission the patient was given 2 oz. of Magnesium Sulphate immediately and one dram of Haimased every four hours. He was put on a low protein, salt free diet with restricted fluids. A 2 cc. ampule of Salyrgan was given intramuscularly that evening. On the second day, he was greatly improved and continued to do well for one week. He then became restless and cerebral irritation was evident. A venesection with removal of 500 cc. of blood was done. His blood pressure remained up. Daily colonic irrigations were started together with administration of 250 cc. of a 10% glucose solution intravenously. Improvement was noted but lasted for only two days when he became irrational again, and jaundice appeared. Hot wet packs were started resulting in slight improvement followed by relapse with marked drowsiness. As the hot packs were not inducing sweating, Pilocarpine, gr. 1/6 subcutaneously was given. The stupor was superseded by cerebral irritation with delirium and its attendant physical activities, so two capsules of Nembutal were given. The patient slept for five hours and was slightly improved on awakening. Daily treatment, as above, was continued but the patient became progressively worse and died on March 23rd.

Autopsy Findings: (For economy of time I shall note only the pathological findings.) The pupils were unequal and dilated. Urea crystals were found on the skin surface of the face. The heart was markedly enlarged, weighing 2 pounds and with a ventricular wall one inch in thickness. The right ventricle was flabby, the papillary muscles hypertrophied and the chordae tendinae contracted. The mitral valve was roughened and there were definite plaques on the aortic arch. The Lungs: The left lung showed evidence of passive congestion. The right presented adhesions posteriorly and at the base with some scarring at the apex. The liver was large and firm with pressure scarring over the right lobe. The Kidneys: The right kidney was markedly

polycystic, measuring 10 x 5 x 6 inches and weighing 5 lbs. It was saved intact for the laboratory. The left kidney was slightly larger, also markedly polycystic, weighing 6½ pounds. On section, it showed a dilated pelvis, numerous cysts varying in size from a pea to an egg and filled with a brownish fluid. Several large perirenal lymph nodes varying in size were found on both sides. The spleen was firm, showing passive congestion and scarring at upper pole. The urinary bladder was moderately distended. The appendix was 8 cm. long.

Anatomical Diagnosis:

1. Bilateral Polycystic Kidneys.
2. Myocarditis.

In reviewing the recent literature on Polycystic Kidneys, I find that all of the writers have agreed that while the condition is not common neither is it rare, many cases being accidentally discovered either at autopsy or at operation for other suspected kidney conditions. Oppenheimer¹ in a very comprehensive article on Polycystic Diseases of the Kidney in the Annals of Surgery, 1934, states that in his series of 60 proved cases, all occurred in 220,000 admissions, and in 6000 autopsies, 14 cases were encountered. In one hospital, 13 cases were found in 2060 autopsies, and in the collected statistics of 23,900 autopsies, 67 bilateral polycystic kidney cases were found. Many of the writers vary in theory of the Pathogenesis of this condition. Hinman² in the Principles and Practice of Urology divides cystic disease of the kidney into Simple and Polycystic, the latter being congenital and of uncertain pathogenesis. He outlines the various theories of the latter as follows:

- (a) Virchow's theory that they are a form of retention cyst by developmental error.
- (b) Bigidi and Severi's (1880) theory that they are neoplastic-like cystadenoma.
- (c) Shattock's, that they are due to the persistence of mesonephric tubules with cystic formation.
- (d) Huber's, that they are due to defective union of ureteral and metanephrogenic fundaments during development.
- (e) Kampmeier's,³ that they are the persistence of early generations of uriniferous tubules. This theory is outlined in detail by McKenna & Kampmeier⁴ in the *Journal of Urology* 1934 (July) and in explanation they have divided the kidney development into devel-

opmental zones of generations of uriniferous tubules. They also reported a case at the same time which I shall mention later.

And lastly that:

- (f) They are due to mal-development (arrested development) of glomerulus and Bowman's capsules.

Hinman² gives the pathology as: "Cysts varying in size from minute vesicles to good sized cysts several centimeters in diameter, scattered throughout the body of the kidney tissue but not communicating with the pelvis, although an occasional one ruptures into the pelvis. The contents of the cysts varies from clear fluid to a turbid viscosity and have been found to contain uric acid, hippuric acid, calcium oxalate, cystin, leucin, tyrosin, blood and cholesterol. The renal substance may be entirely replaced by cysts, the walls of which consist of a framework of fibrous tissue covered by a single layer of cuboidal epithelium which may be thrown into folds simulating papillomata. When renal tissue persists, it lies between cysts and presents progressive changes of atrophy from pressure, and interstitial fibrosis. There may be arteries of varying size lining the cyst walls and hemorrhages accompanied by attacks of pain attend their rupture."

All of the writers bring out that Polycystic kidneys occur at two periods of life—infancy and adult life. All have found that there is a strong hereditary tendency through either sex. In line with this, Dr. Chilton Thorington⁴ of Montgomery, Alabama, reported 5 cases, all of the same parentage, 4 males and 1 female, who died between the ages of 30 and 50.

Infants die within a short time of birth.

Adults present chief symptoms varying widely, the simplest being a tumor plus renal insufficiency. Progress may be slow and many persons live their allotted time gradually showing symptoms of chronic nephritis. Hematuria intermittent and of long duration may be the initial symptom. Cabot⁵ reports a case of this type in the *New England Journal of Medicine* for the week of December 20, 1934, when he presented a case of a 53 year old male complaining of Hematuria with a blood pressure of 240/110 and a urinalysis presenting a large trace of albumin and a Sp. Gr. of 1.012. The definite diagnosis of Polycystic Kidney in this case

(considered in differential) was made when after a complete work-up, the patient was operated upon to stop hemorrhage. Dr. Mallory in the pathological discussion of this case mentions that "Polycystic kidneys which are by no means rare are still seldom correctly diagnosed in life."

In Oppenheimer's¹ series of 60 cases, 59 were adults, one was an infant prematurely born. 37 of the 59 were males, 22 females. 26 of these known cases were dead at the time he published his article. In his table of age incidence none were found up to 20 years of age, two from 20-29, fourteen from 30-39, seventeen from 40-49, eighteen from 50-59 and eight from 60-69 years of age. He feels that the tremendous margin of safety present in the kidneys explains the fact that cases remain symptomless during the first two decades although 29 other cases have been reported by various writers occurring between the ages of 2 and 20. In grouping his patients as to clinical picture on admission (modes of onset or discovery):

Six were accidentally discovered at postmortem examination or operation on the finding of a symptomless mass in the abdomen.

Thirteen cases presented the signs and symptoms of hypertensive cardio-renal disease, and

Fifteen, the frank symptoms and signs of Polycystic kidney as hematuria, loin pain, bilateral loin masses, arterial hypertension and evidences of renal insufficiency.

The others ranged from signs pointing to renal neoplasm, infected hydronephrosis, pyelonephritis; perinephric abscess or renal calculi. As to associated conditions he found enlargement of the heart in 30% of the cases and hypertension with increase in the blood urea in the majority. The hypertensive cases were associated with poor renal function in 20 out of 28 cases.

So, actually the diagnosis of these cases is not easy or simple, always. Hinman² states that in the presence of a tumor (bilateral) plus renal insufficiency a clinical diagnosis is possible but in most cases is not made. Ritchie in 88 cases found clinically palpable bilateral tumors in only eight.

For diagnosis, plain X-rays may show renal enlargements that were not palpable, but pyelography is most informative although defects may simulate other tumors.

Conservative treatment as in chronic nephritis is indicated although surgery must be resorted to in cases of continued hemorrhage or severe distress.

REFERENCES

1. Gordon David Oppenheimer, M.D., New York, N. Y. Annals of Surgery 1934, "Polycystic Disease of the Kidney."
2. Hinman: Principles and Practice of Urology.
3. Charles Morgan McKenna and Otto F. Kampmeier: "A Consideration of the Development of Polysystic Kidney." Journal of Urology, July 1934.
4. Chilton Thorington, M.D., Montgomery, Ala., Journal, M. A. Alabama, December 1934.
5. Cabot: "Report of Clinical Pathological Conferences," M. G. H. New England Medical Journal, 211, December 20, 1934.

SOCIETIES

SPECIAL COUNCIL MEETING

A special meeting of the Council was held Jan. 2, 1936, at the Medical Library, and was called to order at 4:30 P. M. by the President, Dr. Roland Hammond.

Dr. J. E. Mowry, Treasurer, presented a letter of resignation from the Society of Dr. William Francis Duffy of Bristol. In view of Dr. Duffy having reached the age of 65 years, the motion was made and seconded that he be placed on the retired list, and it was so voted.

A letter from the Associated Medical and Social Workers requesting the use of the auditorium in February and March for six evening lectures was presented by Dr. Mowry, Treasurer, and inasmuch as a charge is to be made for this course of lectures, it was moved and seconded that the request be denied, and was so voted.

Dr. Kingman moved that the Publication Committee be authorized to furnish a budget for the RHODE ISLAND MEDICAL JOURNAL, and that the treasurer pay over to the Committee or its agent the funds requested by such budgets, and on being duly seconded, it was so voted.

It was moved that the Publication Committee be empowered to arrange for remuneration on a percentage basis of the Business Manager of the RHODE ISLAND MEDICAL JOURNAL for arranging for commercial exhibits for the R. I. Medical Society's annual meeting. On being duly seconded, it was so voted. Adjourned.

Respectfully submitted,

J. W. LEECH, M.D., Secy.

**REPORT OF THE MILK COMMISSION OF
THE PROVIDENCE MEDICAL
ASSOCIATION**

REUBEN C. BATES, *Secretary*
122 WATERMAN STREET, PROVIDENCE, R. I.

Certified milk in Providence during 1935 was obtained from the following farms: Cocumcussoc Farm, Wickford, R. I.; Cherry Hill Farm, North Beverly, Mass.; Fair Oaks Farm, Lincoln, R. I.; Hampshire Hills Farm, Wilton, N. H.; Walker-Gordon Farm, Charles River, Mass.

Through the courtesy and co-operation of the Boston Commission we have accepted their certification of two farms from Massachusetts and one from New Hampshire.

Bacteriological and chemical examinations of the milk are made in the laboratories of Brown University under the supervision of Professor Charles Stuart. Arrangements have been completed to have

the potency tests on vitamin-D milk performed in the laboratory of Professor Phillip Mitchell of Brown University.

During the past year pamphlets have been given many of the new mothers to acquaint them of the qualities of certified milk. Advertising material has been sent out to physicians and dentists and the yearly conference between the commission and pediatricians of this city was very successful.

The commission feels the time is ripe to recommend to our health officials the advisability of pasteurizing all milk sold in Providence except certified milk.

The personnel of the Commission includes Drs. Harold G. Calder, Chairman, Francis V. Corrigan, George W. Waterman, Robert H. Whitmarsh, Henry E. Utter, Harmon P. B. Jordan, Raymond L. Webster, Banice Feinberg and Reuben C. Bates, Secretary and Treasurer.

MONTHLY AVERAGES OF CERTIFIED MILK

	COCUMCUSSOC			CHERRY HILL (H. P. Hood)			FAIROAKS			HAMPSHIRE HILLS (Whiting's)			WALKER-GORDON		
	B.F.	T.S.	Bacteria per C.C.	B.F.	T.S.	Bacteria per C.C.	B.F.	T.S.	Bacteria per C.C.	B.F.	T.S.	Bacteria per C.C.	B.F.	T.S.	Bacteria per C.C.
January	4.58	13.57	2,500	4.23	13.33	1,280	4.55	14.01	1,107	4.14	13.03	—	4.09	12.87	80
February	4.37	13.31	3,837	4.12	13.13	2,772	4.31	13.62	2,200	4.10	12.95	13	4.15	12.94	1,701
March	4.50	13.44	3,512	4.28	13.32	3,150	4.45	13.52	450	4.10	12.98	2	4.00	12.70	3,215
April	4.31	13.25	3,411	4.00	12.93	5,737	4.72	14.02	572	4.22	13.15	—	3.95	12.68	2,062
May	4.36	13.21	4,383	4.06	12.91	2,260	4.71	14.00	3,405	4.09	12.83	4	4.00	12.63	1,511
June	4.32	13.05	3,412	4.02	12.89	2,762	4.92	14.05	1,464	4.15	13.05	5	4.00	11.53	4,500
July	4.30	13.03	7,464	4.00	12.90	3,350	4.30	13.26	2,525	4.10	12.86	13.3	4.00	12.57	4,566
August	4.25	13.05	14,255	4.16	13.08	2,900	4.27	13.23	9,572	4.00	12.49	7.7	4.00	12.40	7,375
September	4.14	14.97	8,400	4.12	13.08	2,860	4.18	13.19	1,422	4.06	12.89	4.4	4.02	12.77	5,110
October	4.32	13.29	4,905	4.06	12.95	2,240	4.38	13.31	1,885	4.12	12.48	6	4.02	12.87	4,325
November	4.42	13.45	4,193	4.17	13.12	2,750	4.50	13.57	1,187	3.95	12.82	4	4.05	12.90	4,587
December	4.40	13.45	5,835	4.30	13.17	916	4.90	13.86	1,572	4.00	12.77	1	4.00	12.99	4,412
Yearly Aver.	4.35	13.42	5,508	4.12	13.06	2,748	4.51	13.63	2,280	4.08	12.85	5.03*	4.02	12.65	3,620

* Pasteurized

REPORT OF THE 1935 SESSION OF THE AMERICAN MEDICAL ASSOCIATION*

The last annual session of the American Medical Association was unique in many respects. More members attended the meeting than any previous convention. The Canadian Medical Association met with the American Association for the first time. The number and variety of scientific papers was greater than ever before, and the scientific exhibit was the largest in the history of the Association.

Each year the scientific exhibits seem to increase in number, and interest. A definite effort was made

to make the exhibits educational and to correlate them with the scientific program. There were special booths where lectures were given and motion pictures shown on the prevention of asphyxial deaths, diabetes and the use of serums and vaccines. The exhibits also included demonstrations in dermatology, cancer, syphilitic heart disease, hemorrhage in obstetrics, abdominal surgical conditions and the physiological action of the ductless glands. All were exceptionally well displayed and ex-

*Read before the meeting of the Rhode Island Medical Society, September 5th, 1935, held at the Pawtucket Memorial Hospital.

plained either by charts or lectures. The scientific exhibit alone more than justifies one's attendance.

The American Medical Association, in general, seems to have emerged from the depression in a remarkably satisfactory condition. Although 1,700 members were lost by death, the roster contains the names of 1,500 more members than one year ago. At present there are 99,536 members of the Association.

The financial condition, regarded as excellent last year, has also improved considerably. It is more than likely, however, the increased revenue received this year will diminish in succeeding years because of the lowered rates of interest on good securities.

The *Journal* continues to be the foremost medical publication in the world. Its departments reviewing medical literature of the various foreign countries give the American physician a world-wide grasp of medicine. The Therapy of the Cook County Hospital series is another valuable addition. The average number of copies printed each week was 85,711. It is impossible to mention the *Journal of the American Medical Association* without speaking of the *Quarterly Cumulative Index Medicus*. It is doubtful if any other publication renders a service of such magnitude to the medical profession. No other organization would even attempt such a tremendous proposition. Other special publications were continued and improved. It is gratifying to note the usual financial loss sustained by most of these publications was very greatly reduced this year. *Hygeia* incurred a loss of only \$2,000 as compared with a loss of some \$30,000 during the year of 1933. That is comparatively small when one considers the value of such a publication to the public.

The importance to the medical profession of the various councils and bureaus can best be judged by their increased activities.

The Council on Pharmacy and Chemistry has studied in an impartial manner the actions of various drugs and compounds and has informed the profession through the columns of the *Journal* of its findings. The information given affords the medical profession its greatest protection against confusing and unjustified claims of proprietary firms whose chief interest is financial gain. The work of the Council will be more valuable when members of the profession refuse to use therapeutic agents before they have been accepted by the Council on Pharmacy and Chemistry.

The Bureau of Medical Economics has been particularly helpful in collecting and disseminating information in its field. The depression furnished an inspiration for many schemes to alleviate human misery. Sickness insurance plans have been and continue to be the chief aim of many powerful philanthropic societies and non-medical individuals. In order to acquaint the medical profession and the public with the facts the Bureau of Medical Economics has undertaken extensive studies both in America and foreign countries and has published the results in the *Journal* and in the *Bulletin*. Many of these publications are now available in pamphlet form. It may be said that sickness insurance plans, for the most part, provide not for the indigent, but for those who can pay, and, further, place between the physician and the patient a non-medical third party who also must receive a remuneration. Such a plan can be satisfactory only to the third party. The public generally does not understand this phase of the plan. During the coming year the advisability of sickness insurance will be the subject of many high school and college debates. Many of you will be asked by debaters for information. This may be obtained from the bureau which has prepared pamphlets on the subject and will gladly forward them to you. Any scheme pertaining to the health of the public should rest in the hands of the medical profession rather than the laity, and should embody the principles of ethics adopted at the Cleveland session. The state and county societies likewise assume a responsibility in adopting plans for the care of the indigent and low income groups. It must always be remembered and emphasized that voluntary insurance schemes preceded compulsory insurance in those countries where the latter exists. Even where a definite need exists for a plan for the low income group, a carefully conceived plan may serve to inspire lay organizers with questionable motives to develop cheap imitations. There are many other reasons to cause a Medical Society to pause before entering upon any such scheme, chief of which is the actual necessity for any cooperative plan at all.

The Bureau of Legal Medicine has followed the activities of the National Congress and has noted the bills introduced in State Legislatures that pertain to medicine. On the whole there have been passed but few bills of interest to the profession.

The Bureau of Health and Public Instruction, through the personal appearance of its director, by

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exhibits and pamphlets, and particularly by radio, has reached a far greater audience than ever before.

The House of Delegates elected the following officers for the ensuing year: President-Elect, Dr. J. Tate Mason of Seattle, Washington; Vice-President, Dr. Kenneth M. Lynch, Charleston, S. C.; Secretary, Dr. Olin West, Chicago, Illinois; Treasurer, Dr. Herman Kretschmer, Chicago, Ill.; Speaker of the House of Delegates, Dr. Nathan B. Van Etten, New York; Vice Speaker of the House of Delegates, Dr. H. H. Shoulders, Nashville, Tenn.; Trustee, Dr. Ralph A. Fenton, Portland, Oregon; Trustee, Dr. James R. Bloss, Huntington, West Virginia.

Immediately following the election of officers the House voted to hold the next annual Session in Kansas City, Mo., May 11 to 15, 1936.

OBITUARY

FRANCIS J. HIGGINS, M.D. 1894—1935

Dr. Francis J. Higgins died at his home, 216 Waterman Avenue, East Providence, on October 3, 1935, a few hours after he had suffered a cerebral hemorrhage. He was but 41 years old.

Dr. Higgins was born in Providence on August 9, 1894, the son of Michael J. and Mary A. (Horan) Higgins. He was educated in the public schools of Providence, received his pre-medical education at Brown University, and in 1921 was graduated from Tufts College Medical School.

Dr. Higgins served internships at the Metropolitan Hospital in New York City and at St. Francis Hospital in Hartford, Connecticut. He then established an office for the general practice of medicine in East Providence, which community and its environs he served faithfully until his untimely death. He was largely instrumental in the establishment of the "Well-Baby Clinic" of the East Providence District Nursing Association and was the medical director of this clinic since its origin eight years ago.

Dr. Higgins was a member of the Providence Medical Association, the Rhode Island Medical Society, and of the staffs of St. Joseph's Hospital and the Homeopathic Hospital. For several years

he served as an associate on the gynecologic service at St. Joseph's Hospital. He was also a member of the Stark-Parker Post of the American Legion, Riverside Council of the Knights of Columbus, and of the Metacomet Golf Club.

Dr. Higgins was one of the most skillful golfers among the medical profession, and was an ardent traveler, having made many trips around the world, through Europe, Africa, and South America. He never married.

Dr. Higgins was a genuine family physician, conscientious to a fault; a tireless worker, often at the expense of his vitality; a true friend to all his patients. His death is a real loss to the medical profession, to his family, to his patients, to his friends.

EARLE H. BRENNEN, M.D.
HENRY McCUSKER, M.D.

ANNOUNCEMENTS

AMERICAN BOARD OF OPHTHALMOLOGY Room 1417, 122 So. Michigan Ave., Chicago.

1936 Examinations—Kansas City, May 11th, at time of meeting of A.M.A.; and New York City, in October, at time of meeting of American Academy. All applications and case reports must be filed at least *sixty days* before date of examination. For information, syllabuses and application forms please write *at once* to Dr. Thomas D. Allen, Assistant Secretary, 122 South Michigan Ave., Chicago, Ill.

Barbara T. Ring, M.D., announces Hosea Webster McAdoo, M.D., as Medical Director of the Ring Sanatorium and Hospital.

M.D., Tulane University, New Orleans, 1916-20. Interned, St. Louis, Southwestern Railroad Hospital, 1920-21. Resident Physician, Warren State Hospital, Pennsylvania, 1921-23. Instructor Neuro-Anatomy, University of California, 8 months, 1923-24. St. Elizabeth's Hospital, Washington, D. C., 4 months, 1923-24. Medical Officer (Psychiatry), U. S. Veterans Hospital 78, Little Rock, Ark., 1924-29. Assistant Professor of Pathology, Baylor University, Dallas, Tex., 1929-30. Clinical Director, Springfield State Hospital, Sykesville, Md., 1930-32. Superintendent, Springfield State Hospital, Sykesville, Md., 1932-35.

Arlington Heights, Mass., Oct. 24, 1935.

COMMENTS UPON MEDICAL TOPICS

By MALFORD W. THEWLIS, M.D.

Periarteritis Nodosum. Middleton and McCarter, *Am. J. M. Sc.* 762: 291, suggest a biopsy of accessible nodules or voluntary muscle. They cite the tetrad of Meyer and Brinkman—chlorotic marasmus, polyneuritis and polymyositis, striking abdominal manifestations (cramps, vomiting, diarrhea, melena and perforation) and nephritis, as offering a logical foundation for the clinical diagnosis of the disease.

* * *

Twelve deaths from automobile accidents in Rhode Island in one month! A competitor of cancer in mortality rates. Drivers might be made to pass physical examinations before being licensed.

* * *

Here and There: Simple test for early detection of cancer (Gruskin, Temple University) . . . Outfits furnished by boards of health for collecting serum from chancre to make early diagnosis of syphilis possible . . . Larodon for pain . . . Antitularemic serum . . . Intravenous medication for introducing fat substances into babies who cannot absorb fat . . . A new method of producing morphine and codeine without producing crude opium—less cost . . . Hemophilia treated by use of snake venom (MacFarlane) . . . Glucose dressings for severe burns (Belts) . . . Gold salts for arthritis (Forrestier) . . . An apparatus for measuring intensity of X-rays and radium after penetrating human body . . . Dioxyanthranol 1-8 as a substitute for chrysarobin . . . A new test for identification of pneumococci by Dr. Leifson, of Johns Hopkins University . . . D'Amour's serum for bites of black widow spider . . . Rich meat diet for epilepsy and migraine (Foldes) . . . Varicose ulcers: acetylbetamethylchlorine chloride and mild electric currents (Wright & J. Kovacs) . . . New electrical method in gallbladder operations, removes most of danger and serious aftermath. No drains are used (Thorek) . . .

* * *

Benign Lesions of Eye, Ear, Nose and Throat Allen Robinson, *Am. J. of Roent. and Radium Therapy*, 33: 801, 1935, discusses the use of radium for the following conditions: vernal catarrh, hemangioma, polypoid ethmoiditis, fibroma of the nasopharynx, rhinoscleroma, ozena, chronic tonsillitis and chronic lymphoid hyperplasia of the pharynx, tuberculous cervical adenitis, enlarged thymus and leucemia.

Gumma of Bladder Simulating Cancer. Probstner (*Ztsch. F. Urol.*, Leipzig, 29: 273, 1935). The author reports a case of a woman of 70 who entered the hospital with a suspicion of cancer of the bladder. She was thin and cachetic. A diagnosis of inoperable carcinoma of the bladder was made. Treatment symptomatic. A few days later she complained of sores of the back. Wassermann was strongly positive. After 7 weeks of antisyphilitic the patient was free from bladder symptoms. (It is always safer to do a routine Wassermann in old age. Some of these old people react very kindly to antisyphilitic treatment. Most of them deny ever having the disease.—M. W. T.)

* * *

Drugs and Other Methods of Treatment. Foster Kennedy (*Bull. N. Y. Ac. of Med.*, 2: 511, 1935, second series) discusses drugs in neurologic conditions. Allergic treatment of migraine, ergotamine tartrate for the migranous seizure. Headaches: rheumatic yield to salicylates; septic teeth and tonsils as a cause of pain in back of neck and lower occiput; local skull pain after head injury from formation of cerebro-meningeal adhesions. Violent headache caused by pulpitis—equal to that of trigeminal neuralgia. Nocturnal syphilitic headaches; headaches from inadequate sleep and fatigue. Headaches of menses and uterine malpositions. Acetanilide is a poison and bromo-seltzer a menace. Aspirin, phenacetin and caffeine citrate are harmless to nearly everyone in ordinary dosage (5 grains of each for one dose—seldom used). Pyramidon must be used cautiously. Luminal helps the nervously strained; a simple alkaline effervescent is a good habit—exercise is better—and perhaps a tranquil mind is the best of all (and the hardest to achieve.—M. W. T.).

* * *

Moving pneumonia patients to a hospital is risky.

* * *

The Diagnosis of Primary Carcinoma of the Lung. Heacock and King, *Radiology*, 24: 452, 1935, states that while there is no pathognomonic roentgenologic appearance, there is a picture, which, when present on only one side, should always suggest a primary new growth to the radiologist. It should then be regarded as malignant until proven otherwise. Biopsy material removed by the surgeon or bronchoscopist today offers the most reliable method of making this differentiation.